DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OFFICIAL FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 1

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 19, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447, Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 1,420,886.00
b. FFY 2002 $ 18,138,665.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 11c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None, New Page

10. SUBJECT OF AMENDMENT:
The Arkansas Title XIX State Plan has been amended to reflect an inpatient rate adjustment for pediatric hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ray Hanley

14. TITLE:
Director, Division of Medical Services

15. DATE SUBMITTED:
April 19, 2001

16. RETURN TO:
Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437

Attention: Binnie Alberius
Slot 1103

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 04-25-01

18. DATE APPROVED: 27 JULY 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
19 APRIL 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
CALVIN G. CLINE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & STATE OPERATIONS

23. REMARKS:

RECEIVED
APR 25 2001

FORM HCFA-179 (07-92)

Instructions on Back

1. Inpatient Hospital Services (Continued)

Private Pediatric Hospital Inpatient Adjustment

Effective April 19, 2001, all private pediatric hospitals within the state of Arkansas as previously defined in this section of Attachment 4.19-A shall qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited fiscal year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare related upper payment limit specified in 42 C.F.R. § 447.272.

Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

STATE Arkansas
DATE REC'D 04-25-01
DATE APPV'D 07-27-01
DATE EFF 04-19-01
HCFA 179 AR-01-11

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SUPERSEDES: NONE - NEW PAGE